



THE WHARTON HEALTHCARE QUARTERLY

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EDITOR'S LETTER

Back in April, primary elections were held in my state as well as for county judgeships and positions on the school board. When I went to vote, I was dismayed by the practically non-existent turnout. Granted it was the week of Spring break as well as in the midst of the Easter and Passover holidays, so certainly less than optimal timing for exuberant participation in the democratic process.

However, in a year of many “You just can’t make this stuff up” moments, I had hoped there would actually be a long queue at the polling place. Perhaps it is naïveté, wishful thinking, or eternal optimism on my part, but I’m still holding out for that long and winding road in November.

Regardless of which side of the aisle you sit or don’t sit at all, 2012 will be a year both to remember and to go down in the political history books. To that end, this month we have hot-off-the-presses commentary on the recent Supreme Court decision, with additional perspectives to follow in October.

In addition to our standing columns, among the portfolio of articles featured this quarter is our first “From the Halls of Academia” offering as well as two articles of significance relative to their historical ties to the Wharton School - (1) the initial installment of a four-part series on collaboration from CFAR, a private management consulting firm the roots of which were as a research center at the Wharton School, and (2) an interview with Mitch Goldman, WG’75 of Duane Morris, LLP, who shares his experience starting GLS Associates, Inc. with 4 classmates, another of the first healthcare start-ups to emerge from the early days of the Wharton Healthcare Program.

Heads Up:

Shortly after the release of the October edition, we will be sending a **brief survey** to solicit your feedback as we close out the first year of the *Wharton Healthcare Quarterly*. **Your input and active engagement are crucial** to our planning for 2013 and to our optimizing the ability of the *WHQ* to meet your needs in support of the WHCMAA. Just look at it as an “early voting” practice run for November!

Z. Colette Edwards, WG’84, MD’85

Managing Editor

To learn more about Colette,
[click here.](#)

THE PRESIDENT'S DESK

Fellow Alumni, Friends and Colleagues:

Summer 2012 is now well underway, and parts of our country have been feeling the full, if not devastating, effects of record setting heat waves. Protracted tropical storms, out-of-control wild fires, and power outages are likely impacting many of us during a time when we look forward to relaxing vacations with family and friends.

While not the perfect metaphor, I thought the theme of “heat” was an appropriate one. Despite the recent decisions by the Supreme Court, the Affordable Care Act will be hotly debated throughout the Presidential election cycle. Whether it is implemented “intact” or repealed will likely not be decided until the November elections. Whatever the case, it will be modified along the way. In this issue of the *WHQ*, we are privileged to have a respected member of the WHCM community, Dr. Bill Winkenwerder (WG’86 and the newly selected CEO of Highmark in Pittsburgh) offer his opinion on last week’s Supreme Court decision. And in the October edition, additional perspectives will follow from Skip Rosoff (Professor of Health Care Management) and others in the industry. Regardless of our political viewpoints, we all have a great deal invested in the outcome – professionally and personally – and having access to the informed views of the WHCMAA to vet important policy matters is a valuable resource.

Your Board’s activities continue at a fever pitch during the summer, too. We have just received the results of our recent alumni survey and wish to thank all of you (nearly 200 respondents!) who took the time to provide valuable input on a number of initiatives under consideration. We plan to report the detailed findings and our action plan in the next issue of the *WHQ*. In the meantime, the survey results focus on the themes of maintaining connectivity and keeping us informed in this rapidly changing environment:

- Lifelong learning and networking opportunities are imperative.
- Educational content and topical issues are important in the events we hold.
- The currency and accuracy of our alumni directory is critical, and
- Engaging alumni using a wider range of social media will encourage timely exchanges within the Wharton and wider University of Pennsylvania communities.

Planning is continuing full steam ahead for the Annual Alumni Conference. We have organized another world class event and want to encourage you to attend **October 26 and 27, 2012 in Philadelphia** for “*The Restructuring of Our Healthcare System to Improve Accessibility, Quality, and Cost Effectiveness.*”

It is a great time for all of us to network and to debate/discuss where we are headed. I’d like to thank our Board members’ efforts in driving both the alumni survey and the conference. There are a number of alumni (including non-Board members) who have stepped up and carried the ball for us.

Finally, I’d like to acknowledge and congratulate our newest Board members, Vikram Bakhru (’09), Alexis Bernstein (’10) and Kate Reed (’86), as well as re-elected Board veterans Doug Arnold (WG’84), Brian Bushick (WG’89) and John Whitman (WG’78). We are fortunate to have a diversity of demographic, industry, and class representation on the WHCMAA Board and look forward to this group’s contributions to our many efforts.

With best regards for an enjoyable and “cool” summer,

Jay Mohr (WG’91)
President, WHCMAA



Column Editor: Jay Mohr, WG '91,
Managing Director and Co-Founder,
[Locust Walk Partners](#)
To learn more about Jay, [click here](#).

OPEN WIDE: GETTING TO THE HEART OF THE MATTER?

Previously this column has looked at the theme that “oral health is integral to general health” more from the perspective of how dental care is organized in this country than in spelling out its relationship to more broadly systemic diseases which affect general health. The pain of a toothache, the possibility of life-threatening infection from unchecked disease, the difficulty in chewing and change in nutrition due to tooth loss, and the effects on self-esteem, facial appearance, educational performance, social interaction, and emotional well-being are all real and rather self-evident. But what about linkages between poor oral health and conditions that are regarded as more “medical” in nature, specifically heart disease and stroke?

Beginning 20 years ago, and getting more attention of late, a connection between periodontal* (gum) disease and cardiovascular disease has been the subject of hundreds of professional articles, with more than 160 appearing in peer-reviewed publications from 2008-2010 alone. The core of the argument centers upon the role of the inflammatory response to infectious agents in systemic disease. While far beyond the scope of this column to detail, a very concise summation is that infective microorganisms can elicit a host of inflammatory responses in the body. Some of these can go on to damage blood vessel walls, thus promoting the formation of both vessel-narrowing plaques and arterial hardening. Yet a further consequence can be an increased coagulation of the blood, leading to clots that obstruct these vessels. Other mechanisms are also involved, but the end result can be heart attack or stroke.

Periodontal disease is postulated to be a factor in this process by serving as a source of infection and chronic inflammation in the body. With the breakdown of the tooth-supporting structures and bone, including ulceration of the mucosal barrier between the accumulating bacterial plaque and the gums, a portal develops for the entry of oral microorganisms – infectious agents – into the bloodstream for dissemination throughout the vascular tree, thereby leading to the inflammatory chain of events outlined above.

With heart disease the leading cause of death in the United States, and estimates of moderate to severe periodontal disease in the population ranging from 5% among those 35-49 years old to 20% among those over 75, identifying and modifying risk factors (such as periodontal disease) and taking advantage of therapeutic opportunities (regular dental hygiene visits) could have significant impact on public health. That’s the thesis, and the logic appears straightforward. But.....what does the evidence have to say?

To help answer that question, one other simple, yet at the same time complicating, fact needs to be borne in mind. Just as the infectious agent → inflammatory response mechanism is not the sole path for development of heart disease, it is also the case that infection is not the only cause of periodontal disease. Further, the two conditions share a number of risk factors such as age, diabetes, obesity, genetic and ethnic factors, socioeconomic status, and especially smoking.

All these factors, some modifiable and some not, and their interactions, make it extremely difficult to tease out scientifically if periodontal disease is in and of itself an independent risk factor for cardiovascular disease. Indeed, this was the assessment of the Surgeon General’s report, and twelve years later that is still very much the conclusion found in an April 18, 2012 American Heart Association Scientific Statement, based on an extensive review of the literature “Periodontal Disease and Atherosclerotic Vascular Disease: Does the Evidence Support an Independent Association?”



Column Editor: Harris Contos,
DMD, WG'80, Asclepius Consulting
To learn more about Harris,
[click here.](#)

OPEN WIDE: GETTING TO THE HEART OF THE MATTER?

continued

We have perhaps now come full circle in the discussion to consider once again the matter of the organization of dental care and its relationship to dental disease. One question that has not been asked in all the Sturm und Drang over a linkage between periodontal disease and heart disease is “Why are we engaging in relatively esoteric academic and scientific fine points, when the inescapable reality is that our society is tolerating, through the dis-organization of dental care, the existence of a fundamentally preventable disease in its midst?”

Severe and untreated periodontal disease often results in mouth infection, bad breath, loose teeth with difficulty in eating, and eventually loss of teeth with serious cosmetic and financial implications, because a preventable disease was not intercepted and halted at an early stage. Which brings us back to a critical point not much mentioned in all the scientific literature on periodontal disease and its postulated link to other conditions - our poorly organized and financed dental care “non-system” is itself a risk factor for the development of periodontal disease. More on that and some thoughts on remediation in our next column.....

*Periodontal disease means the loss of tooth support structure and surrounding bone, with calculus deposits on the tooth surface and below the gum line. Gum disease stems from the development of inflammation and plaque (calculus) by oral microorganisms not controlled through proper hygiene, i.e. brushing and flossing, and periodic cleanings by the hygienist.

THE PHILOSOPHER'S CORNER

This eclectic standing column features insightful musings, words of wisdom, life lessons, and stepping stones to business success. We'd love to hear from you, so [click here](#) to participate in future editions.

Life Lessons:

If I knew then what I know now, I would have been less distracted by "seeking alpha" and more attentive to "compounding interest" in my career-building efforts.

If I knew then what I know now, I would not have so conveniently presumed that by following the 80/20 rule I was automatically maximizing something.

Favorite Quotes:

- "Health consists of having the same diseases as one's neighbors."
- Quentin Crisp
- "The test of a first-rate intelligence is the ability to hold two opposing ideas in mind at the same time and still retain the ability to function."
- F. Scott Fitzgerald
- "Risk comes from not knowing what you're doing."
- Warren Buffett
- "Each generation imagines itself to be more intelligent than the one that went before it, and wiser than the one that comes after it."
- George Orwell

Recommended Reading:

- *The Art of Decision-Making* by Morton Davis, 1986.
- *Statistics* by David Freedman, Robert Pisani, and Roger Purves, 1978.
- *Between Parent and Child* by Haim Ginott, 1965.



This month's philosopher is Rocky Lee, WG'95.
To learn more about Rocky, [click here](#).

Column Editor:
Z. Colette Edwards, WG'84, MD'85
To learn more about Colette,
[click here](#).

ALUMNI NEWS

Allan Lewis, W'80

Allan Lewis was recently laid off from his first employer in the healthcare provider industry, Partners Healthcare, after four years. He still enjoys healthcare, after completing in 2011 a graduate certificate in Healthcare Informatics from Northeastern University. He is seeking his next healthcare provider/patient-oriented IT position in the Boston area. For more information see <http://allanlewishealthcare.wordpress.com/about>.

Jim Rose, CAS'83

Jim Rose, Senior Vice President, Business Development of Patient Engagement Systems was recently featured in two articles.

Read more: [Q&A: Patient Engagement: 'The Next Frontier for Improving Healthcare'](#)
[Business Intelligence improves the bottom line](#)

David B. Friend, WG'84

David is currently President and Chief Medical Officer of Aseracare, which is a division of Golden Living, a multi billion dollar provider of post acute care services throughout the United States.

His portfolio includes Palliative Medicine, Home Care, and Hospice Services and is responsible for over 10,000 clinicians caring for over 60,000 patients daily.

Tara Broderick, WG'85

Tara Broderick, Former President and CEO at Planned Parenthood of Northeast Ohio was this year's recipient of [The Ellery and Elizabeth Sedgwick Award](#), a special honor awarded to those who have demonstrated an extraordinary commitment to Planned Parenthood.

2012 - David A. Asch, GM'87, WG'89, HOM'96

Throughout his professional career, David Asch has led the way in helping the public navigate the intricacies of the enigmatic health care system.

For the last 12 years, he has served as Executive Director of Penn's Leonard Davis Institute of Health Economics, where he is the Robert D. Eilers Professor of Medicine and Health Care Management and Economics at the Perelman School of Medicine and Wharton. He is also a member of the Institute of Medicine.

Dr. Asch received his bachelor's degree from Harvard University, his M.D. from Weill-Cornell Medical College, and his M.B.A. in Health Care Management and Decision Sciences from Wharton. He was a resident in Internal Medicine and a Robert Wood Johnson Foundation Clinical Scholar at the Perelman School of Medicine.

Dr. Asch's many contributions all touch upon health policy. His main focus is to examine how medical decisions are made and how they can be improved, a perspective that combines economics with medicine and psychology in the area of what is now called behavioral economics. His work has been

ALUMNI NEWS

continued

recognized with many leading scholarly awards and honors, and he is particularly well known for his research on end-of-life care, genetic testing, rationing, organ transplantation, health care quality, and racial disparities in health and health care.

Dr. Asch founded the Department of Veterans Affairs Center for Health Equity Research and Promotion - the VA's national program aimed at understanding and eliminating disparities in health and health care across different races or socioeconomic groups. He also established and directs the Robert Wood Johnson Foundation Health & Society Scholars Program, and oversees the Summer Undergraduate Minority Research Program at the University of Pennsylvania. He greatly expanded and led Wharton's executive education programs to provide leadership training to physicians, nurses, pharmacists, and health system chief executive officers. He chairs the faculty grievance commission for the entire faculty of the University of Pennsylvania.

Dr. Asch was recognized in 2006 with the Christian R. and Mary F. Lindback Award, the University of Pennsylvania's highest teaching award. His other notable awards include: the Alice S. Hersh New Investigator Award from Academy Health (1997), the Outstanding Investigator Award from the American Federation for Medical Research (1999), the Mid-Career Research Mentorship Award from the Society of General Internal Medicine (2004), the VA Under Secretary's Award for Outstanding Achievement in Health Services Research (2008), the Alpha Omega Alpha Robert J. Glaser Distinguished Teacher Award from the Association of American Medical Colleges (2009), and the John M. Eisenberg National Award for Career Achievement in Research from the Society of General Internal Medicine (2010).

Tom Rodgers, C'92 WG'04

Tom Rodgers recently joined Cambia Direct Health Solutions and will be heading up their new ventures group. They will focus on HCIT and Services and will look to build, buy, and invest in new opportunities to help the Cambia health plans diversify. He will continue to be based in San Francisco but will be spending more time in the wet northwest where Cambia is HQed.

THE SUPREME COURT RULING ON OBAMACARE: WHERE DOES IT LEAVE HEALTH CARE REFORM?

Supreme Court Chief Justice John Roberts surprised conservatives and liberals alike when he sided with the Court's four liberal justices to uphold as constitutional the individual mandate to purchase health insurance and much of the rest of the Obamacare health reform law, known more officially as the Affordable Care Act (ACA). Writing for the majority in a 5-4 opinion, Roberts found, however, that the mandate was not permissible under the "Commerce" and "Necessary and Proper" Clauses of the Constitution, which gives Congress broad leeway to regulate interstate commerce, but instead it was allowable because Congress has authority to levy taxes. Roberts determined that the penalty that enforces the mandate is in fact a tax, albeit a modest one.

The court also held, in a lesser noticed but still very important part of its ruling, that the forcing mechanism that Congress had imposed under the law on states to expand their Medicaid programs - withholding all of the federal portion of their Medicaid funds - was not permissible. Therefore, states could voluntarily expand their Medicaid programs to include all individuals up to 138% of the poverty level and accept the federal monies needed to support this expansion, but they could not be forced or threatened by Congress to do so.

In essence, the Roberts' decision was an attempt by the Chief Justice to find an arguable basis to allow the law to move forward - saving the ultimate verdict to the people and future elections, especially the upcoming 2012 election - while setting new but modest limits on the power and authority of Congress to regulate commerce and control the actions of states.

Most saw the Court's decision as a major victory for President Obama, at least in the near term. To be sure, a rejection of the law by the Court would have been a huge defeat for him. And the President and his supporters were clearly very happy. Some have even suggested the Court verdict was an endorsement of the law. However, Roberts was clear to warn, "We do not consider whether the Act embodies sound policies. That judgment is entrusted to the nation's elected leaders."

Chief Justice Roberts also stated, "The individual mandate cannot be upheld as an exercise of Congress' power under the Commerce Clause. That clause authorizes Congress to regulate interstate commerce, not to order individuals to engage in it." He further "clarified" the meaning of the law's "individual responsibility requirement," in essence re-writing it, so that it was no longer a mandate but merely an option: get insurance or pay a mild "tax" penalty. Contrary to the statute, he ruled that anyone who did not have to pay the penalty would have no legal duty to get insurance. So, because there is no mandate, the tax penalty is constitutional.

The court's conservatives were very unhappy. Even Justice Anthony Kennedy, often seen as a swing-vote moderate, declared, "The act is invalid in its entirety." Kennedy went on to say that the administration went to "great lengths to structure the mandate as a penalty, not a tax," challenging Roberts' rationale for upholding the mandate.

Some analysts are now saying Justice Roberts was originally in agreement with the Court's four conservatives and planned to issue an opinion that struck down the law. They postulate he then changed his mind to move in a different direction, not only out of possible concern that the Court might be perceived as "too activist" or "too political," and therefore subject to increasing political attacks, but also out of his belief that the fate of the health reform law ultimately needed to be decided by the people and their elected representatives. Time may reveal more about what happened behind the closed doors of the Court, but for now things will proceed - both on the politics of health care reform and the actual changes associated with the law and the evolving healthcare marketplace.

Contributor:
William Winkenwerder, Jr.,
MD, WG'86

To learn more about Bill, [click here](#).

THE SUPREME COURT RULING ON OBAMACARE: WHERE DOES IT LEAVE HEALTH CARE REFORM?

continued

On the political front, Republican Presidential candidate Mitt Romney wasted no time providing his reaction saying, “What the Court did not do on its last day in session, I will do on my first day if elected President of the United States. And that is I will act to repeal Obamacare.” He went on to declare, “Our mission is clear: if we want to get rid of Obamacare, we’re going to have to replace President Obama. My mission is to make sure we do exactly that.”

Congressional Republican leaders also vowed to repeal the law and are preparing to bring up another vote in Congress to do so. They said they would make the matter of repeal and replacement a central issue in the fall elections, not only for President of the United States but for all of the key House and Senate seats that could determine the balance of Congress in 2013. Furthermore, they promised to make mandate = a “tax” a key plank of their campaign.

President Obama, on the other hand, after declaring “the highest Court in the land has now spoken,” and that the decision was “a victory for people all over this country,” is expected to begin to campaign more visibly and aggressively on the benefits of the law, and to make the point at every opportunity that Mitt Romney also supported a universal coverage law with an individual mandate when he served as Governor of Massachusetts. Most Democratic leaders are feeling reinforced, if not validated, by the Court’s decision.

Regardless of one’s views, it is clear now that the future of Obamacare will be determined by the people and by the upcoming elections. It is not easy to determine which side will benefit most from the Court’s decision. Certainly the decision gave the law new life and the opportunity for President Obama and other supporters to sell its benefits to the public. On the other hand, opponents are more energized than ever to make their voices heard (Romney reportedly raised \$4.6M in the first 24 hours following the Court’s announcement).

My guess is that the health care reform law’s opponents will ultimately benefit politically more than its supporters. The law is still unpopular with the public; a *New York Times* poll just weeks ago indicated 67% wanted it repealed either completely or in part. All polls show that opposition is still greater than support, and strong opposition is very entrenched.

But that does not mean that Romney will be elected, or that Democrats will lose control of the Senate. Those races are going to turn not only on the larger matter of the overall economy as well as local issues, but also on unpredictable factors between now and Election Day.

In the meantime, insurers, hospitals, physicians, and others across the industry will continue implementing, or preparing to implement, aspects of the law that pertain to them. Expect a lot of attention to turn to the states. State insurance exchanges must be established. Governors and state officials must determine what they wish to do regarding expanding Medicaid, a tough task given current budget difficulties in most states. Several Governors already have promised that their states will not expand their Medicaid programs, but such sentiments could change with time. Employers must prepare for compliance with the law. Individuals, especially those who will be expected to help finance the law, must begin to prepare for their taxes to increase, with both Medicare wage taxes and investment/capital gain taxes set to rise in 2013 for upper income individuals.

In six months we will have a clearer picture of where things are really headed. But for now, if you are in the health care industry, it is a time to batten down your hatches for change, and if you are a concerned voter, to decide what you really think and believe about the Obama health care law and who you support for Congress and President. The Court’s ruling has clarified Constitutional concerns about the law, but the future of health care reform is still unfolding, and will continue to do so for the rest of this decade.

WHERE IS THE “I” IN TEAM? – WHY COLLABORATION MATTERS IN HEALTHCARE

This is the first in a series of four articles exploring opportunities to improve collaboration in healthcare settings - between institutions, between physicians and administrators, and within inter-professional teams. In addition to making the case for more effective collaboration, we will describe practical tools that can be applied to improve collaboration and thereby overall institutional performance, with the overarching goal of providing better patient care.

On Friday, May 9, 2003, a 5-year-old boy was undergoing diagnostic testing for his epilepsy at Children’s Hospital in Boston when he suffered a massive seizure. Two days later, on Mother’s Day, he died. Despite the fact that he was in intensive care at one of the world’s leading pediatric hospitals, none of the physicians caring for him ordered the treatment that could have saved his life.

The death was tragic, but even more troubling from an organizational perspective was the series of events that led up to it. The Massachusetts Department of Public Health investigated the death, and, reporting on the results, *The Boston Globe* said, “The investigation portrays a situation where lines of authority were deeply tangled, and where no one person had accountability for the patient. Each of the doctors who initially worked on the case - two at the bedside and one consulting by phone - told investigators that they thought one of the others was ‘in charge.’” In the end, no one was in charge.

This is a striking example of how even the most talented clinicians in one of the world’s best hospitals can fail not only to provide adequate care, but to save a savable life - all because the lines of authority were unclear. The lack of clarity resulted in this team’s inability to collaborate effectively at a time when the stakes couldn’t have been higher.

This story reflects just one of many difficult collaboration challenges in healthcare. So why, beyond this most obvious and heartbreaking example, is it important for healthcare organizations to improve collaboration?

Collaboration has evolved from being a “good idea” to a genuine business imperative. The shift in healthcare delivery models is well underway - from fragmented activities and processes focused largely on healing the sick, to coordinated care and an emphasis on preventing illness and promoting wellness. The new model, and the regulatory landscape in which it is taking shape, mandates that leaders look within their organizations and across their systems and communities to align and connect the relevant moving parts. Leaders need to steer what can feel like an unwieldy collection of projects, processes, teams, and partners in the direction of accountable care networks and other collaborative changes unfolding in real time. And the fact is, improving coordination and collaboration will be a major factor in determining which players in the healthcare landscape survive.

But before going any further, let’s first define what we mean by “collaboration.”

What is “collaboration” anyway?

Merriam-Webster defines collaboration as “working jointly with others or together, especially in an intellectual endeavor.” While true, we find that it may be more helpful to define what the concept looks like in actual practice.

Organizations that excel in effective collaboration strike a balance between structure and flexibility - and the equilibrium between these two depends on an organization’s mission, size, regulatory reality, and many other factors.

Contributors:
Carey Huntington and
Jennifer Tomasik

To learn more about Carey and
Jennifer, [click here](#).

WHERE IS THE “I” IN TEAM? – WHY COLLABORATION MATTERS IN HEALTHCARE

continued

Collaborative organizations create and develop:

- an environment where decision-making authority is clear and effective problem-solving dialogues are encouraged.
- teams that cross boundaries of role, professional identity, and experience in ways that integrate their skills to produce better outcomes.
- teams with the ability to reliably and consistently complete tasks and processes, including the ability to function effectively when routines are not in place.
- the capability to meaningfully engage stakeholders within and outside of their organizations.

Together, the individuals, departments, or units create a whole that is greater than the sum of their parts because expertise can be both differentiated and integrated. For example, interdisciplinary rounding in hospitals has proven to be a powerful way to bring together physicians, nurses, therapists, social workers, and others to provide their individual expertise and integrate it to craft a shared care plan for their patients.

But most importantly, effective collaboration means working with, and through, differences. Any highly functioning team will, by its very nature, have differences (of ideas, perspectives, etc.). Ideally, individuals collaborating toward some end will each offer innovative solutions that compete for “idea space” at the table. As a result, the differences represented across the ideas can also serve as the source of conflict. This leads to what we call “the collaboration dilemma” - the very differences that can create value can also destroy it. What happens, for instance, when the rounding team does not agree with each other about how best to manage a patient? To gain the best results, effective collaboration requires that teams not only value differences, but also encourage them to be surfaced and push the team to work through them.

Viewed in this way, collaboration is neither an event nor an idea. Collaboration is not simply “agreeing to get along.” Effective collaboration is an ongoing, systematic, strategic process. It is a commitment to understand and integrate different points of view in the service of a better overall outcome. Collaboration is a business imperative - and it is particularly important in healthcare.

If effective collaboration is important, and building collaborative skills is critical to future success, how does one actually get better at collaborating? The next three articles will take a closer look at the business case for collaboration and opportunities to improve collaboration in different healthcare settings. The series will introduce useful tools that can help strengthen collaboration and improve overall organizational performance - all to provide better patient care.

CFAR is a private management consulting firm that helps organizations change what's getting in the way of their success. Originally a research center at the Wharton School, then called the Wharton Center for Applied Research, CFAR became a private management consulting practice in 1987. It has been known since then as the Center for Applied Research (CFAR, Inc.) Clients seek out CFAR for its strong combination of business analytics and behavioral insight. The firm serves clients worldwide from offices in Philadelphia and Boston.

For more information on this or related materials, contact CFAR at info@cfar.com or 215.320.3200, or visit our website at <http://www.cfar.com>.

“PATIENT-CENTRIC” NOT “TEST-CENTRIC” COLORECTAL CANCER SCREENING

Colorectal cancer is a major health issue. In 2012, it is estimated that 143,000 people will be diagnosed with the disease, and 52,000 will die from it. The cost of treating metastatic colorectal cancer has skyrocketed with the advent of new chemotherapeutic agents and now runs as high as \$150,000 to \$200,000 per patient. Fortunately, colorectal cancer is one of the most curable cancers when detected early, thereby avoiding the high mortality and expense of late-stage disease, and it is well documented that such early detection can be achieved through effective screening programs. Yet despite the significant effort and expense of education and advocacy programs, insurance reforms, and technology development over the last decade, colorectal cancer screening has perhaps the lowest participation rate of all screening tests, with nationally reported compliance rates of 54%, according to the HHS Healthy People 2020 initiative. This raises several questions. “Is this due to the execution of our current plan or do we need a different strategy? Would a more patient-centric (vs. test-centric) approach be a more effective strategy to actually accomplish screening rates greater than 54%?”

The US Preventive Services Task Force (USPSTF) has advocated colorectal cancer screening for many years. In their 1995 guidelines the USPSTF recommended only guaiac FOBT (fecal occult blood test) testing and/or sigmoidoscopy. However, these tests did not achieve high adoption due to low performance, patient dislike, and an overall lack of strong, public advocacy. It wasn’t until 1998, when Katie Couric lost her husband, Jay Monahan, to colorectal cancer that things began to change dramatically.

Ms. Couric took on colorectal cancer as a public cause and had her own colonoscopy performed on national TV in 2000. Physicians and public health experts joined in the effort, and in 2002, colonoscopy was included in the USPSTF guidelines. In the following 10 years, new tests were developed (including the fecal immunochemical test or “FIT” - an improved version of the older FOBT test, as well as CT colonography and molecular tests), but colonoscopy became the “gold standard” and the primary recommendation of advocacy groups and specialists. Many health insurers began to cover screening colonoscopies at 100%, and most patients are now told by their PCP to get one every 10 years beginning at age 50.

While colonoscopy is the best diagnostic procedure for colorectal cancer, is it the best screening **strategy** to achieve greater than 54% compliance? Consider its perceived disadvantages - potential procedure complications, an odious 12 hour bowel cleansing, embarrassment, the negative logistics of time off from work, and the need to be transported to and from the procedure. Given only the option of colonoscopy, there’s little wonder why asymptomatic individuals who perceive themselves to be at low-risk don’t rush to get screened. Additionally, with limited time, do physicians even have the opportunity to discuss the benefits of screening, the pros and cons of the various options, and to overcome patient reluctance?

Screening strategies can be evaluated by using the formula “*test performance x patient compliance = screening performance.*” An interim report of this type of evaluation was published in the February 23, 2012 edition of *The New England Journal of Medicine*. The randomized 10-year study being conducted in eight regions of Spain enrolled 57,404 subjects who were divided equally into two groups.

One group was offered one colonoscopy screening at initiation, and the other was offered a FIT test every two years over the ten-year study, with colonoscopy being performed for any positive results. Participants were notified in advance of the group to which they were assigned, but were allowed to crossover to the other test if they preferred it.

Contributor:
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“PATIENT-CENTRIC” NOT “TEST-CENTRIC” COLORECTAL CANCER SCREENING *continued*

Table 1 indicates more participants attended initial screening meetings in the FIT arm, and significantly more participants overall elected a FIT test after the screening meetings.

Table 1	Colonoscopy Screening Arm	FIT Screening Arm
Participants Enrolled	28,708	28,696
Participants Attending Screening Meeting	7,368 (28%)	9,512 (36%)
Participants Electing Colonoscopy	5,679	117
Participants Electing FIT	1,706	9,353

Table 2 shows the outcome of testing.

Table 2	Colonoscopy (either arm)	FIT (either arm)
Procedures/Tests Performed	4,953	10,611
Cancers Detected ¹	27	36
Advanced Adenomas Detected	493	252

¹Tumor stage (I/II/III) by test was similar: Colonoscopy: 70%/22%/7% – FIT: 67%/17%/17%

This study confirms that the ability of colonoscopy to detect colorectal cancers and adenomas (colon polyps with the potential to turn into cancer) is superior to FIT tests. However, true to the formula, because of the increased patient compliance with FIT testing, more cancers were found with this test, and it was the more effective screening strategy. In addition, the FIT group will receive another 4 tests over the life of the 10-year study, perhaps adding to its advantage in cancer detection and narrowing the gap in advanced adenoma detection.

The body of evidence supporting the effect of patient compliance on screening effectiveness continues to grow. The April 9, 2012 edition of the *Archives of Internal Medicine* reported results from an NIH-funded study conducted in the San Francisco Community Health Network, which examined whether the type of colorectal cancer screening option which was recommended influenced patient adherence. Of the 997 participants, 58% completed their screening. However, participants who received a recommendation for colonoscopy completed screening at a significantly lower rate (38%) than participants with a recommendation for FOBT (68%). *Perhaps most interestingly, 69% of patients given a choice of either test completed their screening.*

It is reasonable to believe that a comprehensive patient-centric approach to screening would lead to higher compliance. In such a scenario, a physician would assess a patient's family history and risk factors for colorectal cancer and what that means in a given individual circumstance, educate about the benefits of screening and early detection, discuss the pros and cons of the various test options to determine which one the patient is most likely to perform, and then follow up to make sure that the test was performed promptly and at recommended intervals. But will this ever be feasible in the physician office setting? If not, are there other effective ways to implement a comprehensive patient-centric approach to screening?

“PATIENT-CENTRIC” NOT “TEST-CENTRIC” COLORECTAL CANCER SCREENING *continued*

One such program, developed by ScreenCancer, provides such a service through use of an outbound call-center, highly trained screening Navigators, and sophisticated algorithms optimized to insure an individual, patient-focused conversation. In this service, patients are contacted at home, where their personal risk factors are assessed, followed by a discussion of screening to educate and, most importantly, to identify and overcome barriers and gain commitment to take action.

Both colonoscopy and FIT testing are stressed as preferred options, but information can be provided on all available tests. Once a test is selected, an appointment can be made or a FIT test ordered and sent directly to the patient. The patient then receives a follow-up call to ensure testing has occurred and all test results are reported to the patient's physician.

The ScreenCancer program was piloted last year with employees of a county government employer in the Midwest as published in the June, 2011 edition of *National Health Care Reform Magazine*. While the study population already had above average baseline compliance, colorectal cancer screening was nonetheless increased from 68% to 87%, with 71% of non-compliant participants choosing a FIT/FOBT test and 29% electing colonoscopy. In addition, participants rated their overall satisfaction with the program as a 4 on a 1-5 scale (5 highest).

When considering the importance of a patient vs. test strategy, it is important to understand the barriers to screening. In the ScreenCancer pilot study, which also covered breast, prostate and cervical cancers with its Navigator service, patients were asked why they had not been screened. For breast, cervical and colorectal cancer screening, the number one barrier to testing was time availability (essentially a surrogate for it not being a priority which is perhaps an education issue). However, for colorectal cancer, the second and third highest barriers were fear and cost, barriers that were not identified for the other cancer screenings. Not having the opportunity to understand and address such procedure-specific concerns in a “one-size-fits-all” strategy could significantly limit compliance.

In addition to offering such a service through self-insured employers and insurance plans, this type of service could function adjunctively to Accountable Care Organizations (ACOs). In this model, the PCP would not use valuable time at the patient's physical, but rather refer the patient directly to a screening service to have a more comprehensive, yet cost-efficient screening conversation, test scheduling and follow-up program. The cost of such a program can be well under \$50 per enrolled patient for the first screening, with subsequent use at future screening intervals even less.

Over the past decade, millions of dollars have been spent developing and marketing colorectal cancer screening tests with improved performance and patient convenience factors, while relatively little has been spent on implementing more effective ways to increase patient compliance with any test. The result so far has been only a modest increase in screening rates.

A better strategy to increase colorectal cancer screening may be to (1) prioritize tests with good performance, inherently higher patient acceptance, and reasonable cost, and (2) combine this approach with cost-efficient education, intervention, and follow-up programs which offer patient involvement and choice to maximize compliance. By focusing on patients and not tests, the outcome of such a strategy would likely be more people getting screened, more cancers caught early, less metastatic disease and overall healthcare cost savings compared to the current “gold standard” strategy.

INCENTIVES AND HEALTH BEHAVIOR: USING BEHAVIORAL ECONOMICS TO MAKE PROGRAMS MORE EFFICIENT

In recent years the field of behavioral economics has received increasing attention because its depiction of people as ‘humans’ who are predictably irrational rather than ‘econs’ who behave like rational, expected utility maximizers has both been empirically validated through extensive academic work and because this perspective fits better with the life experiences of many individuals. As humans, people tend to: (1) be disproportionately affected by the present (as opposed to the future), (2) make decisions based on how they feel (as opposed to numeric calculations of expected utility), (3) change their minds often (as opposed to having time-consistent preferences), (4) evaluate decisions based on their starting point (reference point), and (5) be very susceptible to framing effects and loss aversion. These common decision errors (relative to full rationality) often conspire to make unhealthy behaviors, such as those leading to obesity, more likely.

Embedded in Section 2705 of the Patient Protection and Affordable Health Care Act (PPACA) is a provision that could have significant implications for both the health and finances of employees nationwide. Beginning in 2014, employers may adjust the total amount of employer and employee health insurance premiums by up to 30% (50% at the discretion of the Secretary of Health and Human Services) based on outcome-based wellness incentives. Such rewards can “be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan.”

Employers are moving steadily toward greater use of outcome-based incentives, given ongoing concerns about health care costs and the attractiveness of tying incentive payments to improvement in intermediate outcomes that improve health and have the potential to reduce health care costs. Examples of outcome-based incentives that could be used would include incentives targeted to improving body mass index (BMI), smoking status, blood pressure, and LDL (“bad”) cholesterol. The recent Supreme Court Decision may mean the utilization of such incentives in employer benefit strategies may increase even further.

The hope behind this ACA provision is that it will improve health-related behavior and reduce the prevalence of chronic disease caused by unhealthy lifestyles. Our research and that of other behavioral economists shows that this premise cannot be assumed. Because not all incentive programs are alike and many factors besides incentive amount strongly predict impact, a change in incentives will not automatically lead to a change in behavior. The effectiveness of such programs depends critically on how the incentives are timed, delivered, and framed. Several factors might make insurance-premium adjustments (the most common mechanism for implementing incentives among large employers) less effective dollar for dollar than other potential approaches.

In a commentary published recently in the fall of 2011 in the *New England Journal of Medicine*, we discuss that the same decision errors which contribute to poor health-related behaviors, can be used to “supercharge” incentive programs so they motivate behavior change more effectively than simple premium adjustments. For example, in making decisions, people place more weight on the present than the future - and so are more attracted by immediate than delayed benefits and more deterred by immediate than delayed costs.

Many behavioral patterns which undermine health involve immediate benefits and delayed costs (for example, eating provides immediate gratification but may cause later obesity) or immediate costs and delayed and often uncertain benefits of better health years later (such as the inconvenience of taking a drug or undergoing a preventive medical procedure). From this perspective, attempts to motivate behavior change through annual premium adjustments are unlikely to be maximally effective because the consequences are delayed.

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To learn more about Kevin, David and George, [click here](#).

INCENTIVES AND HEALTH BEHAVIOR: USING BEHAVIORAL ECONOMICS TO MAKE PROGRAMS MORE EFFICIENT

continued

Ideally, incentives should provide small but tangible, frequent, and positive feedback or rewards. A program that promotes exercise with a year-end rebate for gym attendance or one providing a small year-end reduction in one's health insurance premium is far less likely to succeed than one providing incentives, as well as symbolic encouragement, at every visit. Similar concepts apply to most health-related behaviors, such as smoking or medication adherence, for which incentives might bring immediate and frequent attention to otherwise delayed benefits.

Another relevant concept from behavioral economics is mental accounting, which reflects how people tend to categorize monetary receipts and payments. For instance, the effect of rewards (or punishments) diminishes when they are bundled into larger sums of money. Thus, a \$100 discount on premiums (that is direct-deposited in someone's paycheck) may not even be noticed, whereas a separate \$100 check or gift card in the mail is much more likely to get someone's attention. Furthermore, a separate check or gift card is more likely to be motivating because the recipient may feel entitled to spend that money on something to reward him/herself, whereas the money deposited in a bank account likely will just go to pay ongoing household expenses. In essence, increases or decreases in health insurance premiums that are deducted from periodic paychecks are less salient and effective than similar financial incentives provided separately.

In a recent test of these concepts published in the *American Journal of Health Promotion* in February 2012, we applied some of these principles to improving low rates of employee participation in a corporate wellness initiative, a common challenge for employers. This employer had offered \$25 for completion of health risk assessments (HRAs) and achieved participation rates close to 40%, which they wanted to increase. They planned to take the economically rational approach of increasing the incentive amount to \$50 (in this case using grocery gift certificates). We convinced them to test the increase to \$50 vs. a lottery in which those employees in the lottery group who completed an HRA were entered into a weekly lottery (\$25 cumulative expected value) that incorporated regret aversion and social pressure. Those in the grocery gift certificate group who completed an HRA received a \$25 grocery gift certificate. A control group received just the standard \$25 for HRA completion.

To run the lottery, the workforce at each of the worksites assigned to the lottery group was divided into teams of 4 - 8, and over a four-week period one team was chosen at random at each worksite. Members of the team who had personally completed an HRA won \$100, and those who hadn't were informed they would have won \$100, thereby utilizing anticipated regret, which has been shown in several other settings to greatly augment motivation. To utilize social norms, members of groups with greater than 80% participation would each receive \$125 if they had personally completed an HRA.

The results highlighted a basic principle of behavioral economics – that a dollar is not necessarily equal to a dollar, e.g., the effectiveness of an incentive depended on how it was delivered. HRA completion rates were significantly higher among participants in the lottery incentive group (64%) than both the grocery gift certificate (44%) and control groups (40%). This phenomenon was observed despite lottery winners being paid through increases in their paychecks, while employees in the direct payment group were compensated with grocery gift certificates. This design choice was made by the company and introduced a possible confounding factor. It is likely that this difference between incentive types biased the results towards lower effectiveness in the lottery group, since rewards paid as part of paychecks are taxable and -- as described above under mental accounting -- because they are bundled together with larger sums of money, are likely to be less noticeable to employees than grocery gift certificates.

This study was the first to demonstrate that a lottery-based incentive approach which incorporates ideas from behavioral economics can be more effective than an actuarially-equivalent direct incentive.

INCENTIVES AND HEALTH BEHAVIOR: USING BEHAVIORAL ECONOMICS TO MAKE PROGRAMS MORE EFFICIENT

continued

This finding is important for two reasons. First, many employers use incentives to encourage healthy behaviors by employees, and using these dollars as efficiently as possible is essential to maximizing their collective impact on health. For example, a nationwide survey of employers by Buck Consultants found that 77% of employers report using incentives for HRA completion, with the average dollar value of the incentives equal to \$163 per employee, but with values extending as high as \$2,000 per employee in some programs. One evaluation of the impact of HRA payments nationally concluded that achieving a completion rate of 64% using economic incentives requires a payment of about \$115, as compared to the \$50 expended in this study using a behavioral economic incentive.

Secondly, many employers have struggled to drive broad participation in critical health and wellness programs in a cost-effective fashion. As employers strive to achieve higher rates of engagement in wellness programs to control health costs, incentive designs that amplify the motivation to participate may be essential to achieving clinically significant effects.

According to a 2011 Towers Watson/National Business Group on Health survey, an estimated 80% of large employers would be utilizing incentives for healthy behavior among their employees in 2012. Many of the approaches being used are more similar to premium adjustment (which presumes economic rationality) than the behavioral economic HRA example we give above. Our concern is that if Section 2705 is primarily implemented by adjusting next year's premiums for a given employee based on changes in biometrics over the next 12 months, this approach will be less likely to improve health or health behavior than better designed alternatives and more likely to simply result in higher-risk employees paying higher premiums.

The field of behavioral economics has much to contribute both to the insight into, as well as the design of interventions, that can improve health. The University of Pennsylvania has become an epicenter for cutting edge research in this area - Wharton, the School of Medicine, and the Leonard Davis Institute of Health Economics are the home to the Center for Health Incentives and Behavioral Economics, one of two NIH-funded Centers in behavioral economics and health in the U.S. We are actively working to address many of the challenges related to high rates of unhealthy behavior among Americans by carefully designing and rigorously evaluating incentives for healthy behavior. For more information on the Center's activities please see <http://chibe.upenn.edu>.

THE WHARTON HEALTHCARE QUARTERLY INTERVIEWS MITCH GOLDMAN, EQUITY PARTNER OF DUANE MORRIS, LLP

Mitch Goldman WG'75 recounts his experience starting a health care consulting business, GLS Associates, Inc., with four of his Wharton Healthcare classmates in 1974. The business, which was sold in 1990, was one of the first healthcare start-ups to emerge from the early days of the Wharton Healthcare Program. He is currently an equity partner in the health law practice group at Duane Morris, LLP where he advises health care start-ups and health care providers.



To learn more about Mitch, [click here](#).

Wharton Healthcare Quarterly (WHQ): Mitch, thanks for your time today and for inviting us to take a look back to the early days of the program. What was it like then and how does it compare to the opportunities available in 2012?

Mitch: Wharton was a very different place then than it is now. In the 70's, Wharton offered only one course on entrepreneurship - "How to Write a Business Plan." Only one of us took it. Most classmates came to Wharton to go into finance. Healthcare was a relatively new program. Now, a significant number of students come to Wharton to start their own businesses, and healthcare is an integral part of the MBA experience. There are business plan competitions for funding, and Wharton is turning out young, successful entrepreneurs who know how to raise money, build enterprise value, and execute exits.

WHQ: Whose idea was it to start the business?

Mitch: GLS was the collective idea of several of my classmates - Roger LeCompte, Dick Latuchie, Bill Garrow, and Susan Sargent, my wife of 36 years. The early 70's were a time of significant change in healthcare. HMO's were just starting to grow after the signing of the HMO Act of 1973 by President Nixon. Investor-owned hospitals were just getting off the ground and bringing business management skills to that healthcare sector. We thought with our recent training in marketing and strategic planning, we could offer a skill set to hospitals, HMOs, and other healthcare providers that was not readily available. Most of us had taken a corporate planning course with Professor Hasan Ozbekhan. He inspired us to follow our dreams.

During the fall of 1974, we discussed our ideas with a number of faculty members in an attempt to convince them to sponsor the creation of a business plan as our advanced study project. However, most were focused on business research rather than the type of real life application we wanted to tackle. But Professor Stanley ("Steve") Brody, who had appointments at both the medical school and Wharton, stepped up to be our patron. Brody was tough, challenging, and taught a social entrepreneurship course which captured our imagination. We felt he would be the right person to help us, and our instincts were right.

Our interaction with Brody was always a tense and frustrating experience. He challenged every assumption we made, pushed us to look at the big picture, and ripped all of our writing to shreds for not being specific enough. In other words, he saved us from going up in flames before we would even have had a chance to launch. By the time we finished the project, we learned a lot about each other and about ourselves.

WHQ: Was it challenging to venture out onto what was then "the road less traveled"?

Mitch: The decision to execute the business plan was very difficult as we all watched our classmates get real offers from consulting firms, commercial banks, and hospitals. In the end, Roger and Bill chose to take more lucrative offers.

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Z. Colette Edwards WG'84, MD'85

To learn more about Colette,
[click here](#).

THE WHARTON HEALTHCARE QUARTERLY INTERVIEWS MITCH GOLDMAN, EQUITY PARTNER OF DUANE MORRIS, LLP

continued

Dick, Susan, and I chose to take the “big risk.” The reason it was so easy for us to make the decision? We didn’t know any better! We believed we had little to lose, but as our friends were taking jobs with good salaries, the pressure to make the business work started to build. To help guide us through the initial growth phase, we created an advisory board that included Professors Brody and Ozbekhan. At Brody’s urging, we paid each board member \$100 per meeting because he felt unless we paid the members, we would not value the advice.

Unlike most start-ups today, which usually raise capital from family and friends, we took out a very small loan from the Small Business Administration, rented a small apartment near the campus that served as both a bedroom and an office, and GLS Associates was off and running.

WHQ: Do you remember your first client?

Mitch: We landed one of our first clients through a Wharton seminar that was held prior to graduation. The President of Pfizer, Ed Pratt (who was also a Penn board member) spoke at a dinner which we attended with the hopeful anticipation that he would hire us. After the dinner, Susan charged Ed, told him we were starting this new business, and that Pfizer should hire us. Within a few weeks, we were meeting in the President’s office with all the division presidents. Mr. Pratt introduced us as “young budding capitalists” and told them to do their best to find projects for us. As someone who had just lived through the “anti-establishment sixties,” the term “capitalist” made me squirm. But the Pfizer leadership team found some good projects for us, and the business was off and running. I soon forgot about the capitalist thing.

WHQ: So what happened next?

Mitch: The business grew slowly, adding new consultants as we brought in new business. In 1977, *Philadelphia Magazine* listed us among the “77 People To Watch.” Like most professional service businesses, GLS Associates had its ups and downs. By 1995, after President Clinton’s failed attempt to pass a new health plan, we decided to merge GLS Associates with a large, well-known hospital consulting firm, Chi Systems in Ann Arbor, Michigan. That decision was the end of GLS. Susan went with Chi Systems, Dick went into hospital administration, and I started a health law practice, Goldman and Marshall, P.C.

WHQ: In retrospect, was it all worth it?

Mitch: It was a great learning experience. The small business journey is not for everybody. It is challenging, requires intense commitment, and was very stressful. At times, Susan, Dick, and I second guessed the decision. While we did not have the “big exit” every entrepreneur dreams about, we enjoyed having control over our lives, being totally responsible for the consequences of our decisions, and, most of all, having fun.

I use my skills as an entrepreneur every day. As a partner at Duane Morris, I started a medical malpractice insurance company for physicians, from designing the product and raising all the capital to growing the staff. The company is now the 3rd largest physician’s medical malpractice company in Pennsylvania. I also advise healthcare start-ups.

And it looks like the adventure Susan and I began has turned into a “to be continued” story. I see the entrepreneurial spirit of the current generation every day in our children, Jenna and Andrew, who are both entrepreneurs. Jenna, 31, is in her third start-up and Andrew, 27, started his own private equity firm and is completing his first acquisition.

DOGS WALKIN' THE TALK OF HEALTHIER LIFESTYLES

As a Penn Med student in the late 1980's, I recall being lectured on the importance of medical research. We were told the results of such work would occasionally lead us in directions that were not anticipated. We were also reminded of the importance of analyzing the results critically and comprehensively without bias and following them wherever they might lead. At the time the advice seemed obvious, but in the years since I have come to appreciate such action is not always easy. I believe that my personal health journey has relevant public health implications and reinforces why we must pay attention to research, even when such results may bring into question current dogma, and even implicate our culture.

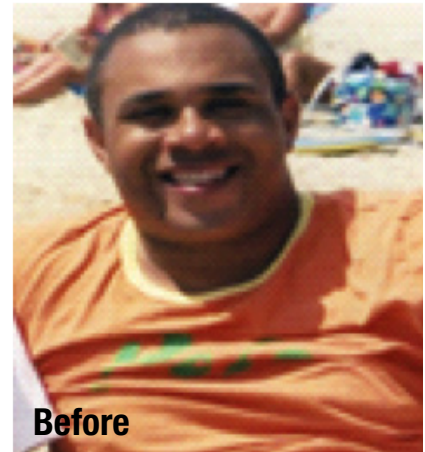
Several years ago, at the time of my routine physical exam, my doctor informed me that I was pre-diabetic and my LDL (bad) cholesterol was elevated. I was also obese. As a physician in my mid-40's at the time, I was quite aware that these were risk factors for premature death. I was feeling much more like a patient - quite vulnerable, concerned, and helpless.

When my doctor gave me the prescription, it was simply for healthy lifestyle changes. He suggested I read "The China Study" by T. Colin Campbell, Ph.D., which I promptly did, and which thankfully changed my life.....for the better. It also provided me with a different lens through which to view some of the greatest challenges that face the medical profession.

Adopting a plant-based, whole foods diet as advocated by Dr. Campbell, and a regular exercise and stress reduction program (as described in publications by Dr. Dean Ornish), I was able to lose more than 50 pounds, "cure" my pre-diabetes, lower my LDL cholesterol to the normal range, and lower my total cholesterol by approximately 40 mg/dL to under 150. My body inflammation (a risk factor for heart attack), as measured by a lab test called C-reactive protein (CRP), also improved significantly. I was sold.

In my family, obesity, type 2 diabetes, hypertension, heart disease and stroke are frequent co-morbidities and have resulted in much premature death. "The China Study" research clearly demonstrates that these diseases and many others, including cancers that frequently occur in Americans, are preventable in most cases, since diet and lifestyle generally "trump genes." In my opinion, we doctors, although well-intentioned, spend considerable time evaluating patients' family medical histories, often leaving them with the misconception that their genes hold their likely destinies. Simply put, the diseases that are responsible for the deaths of most Americans can be prevented by a healthy diet and lifestyle in the majority of cases.

The *New York Times* has referred to "The China Study" as the largest and most comprehensive ever undertaken on the relationship between dietary patterns and development of disease. In rural areas of China, the mean total cholesterol was 127 mg/dL. Rates of chronic disease were generally much lower than in the United States. Interestingly, when these rural Chinese populations migrate to Western countries and adopt our diet and lifestyle, their rates of chronic disease soar to Western levels.



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DOGS WALKIN' THE TALK OF HEALTHIER LIFESTYLES

continued

The diet of the rural Chinese in the study consists of mainly plant-based, low-fat, whole foods with some fish, while our Western diet is high in animal-based foods, including milk and dairy, refined carbohydrates, sugar, salt, and saturated fats. The “China Study” research strongly supports that these dietary differences are largely responsible for the much higher rates of heart disease, diabetes, stroke, many cancers, and other chronic diseases in Western cultures, including the United States.

Armed with Dr. Campbell’s research, and that of other researchers, including Drs. Dean Ornish and Caldwell Esselstyn, I set out to “scream from the rooftops” how my personal experience with lifestyle changes strongly supported the China Study research, beginning with my physician colleagues. But.....not so fast. While none contested the validity of these studies, most were reluctant to change their personal diets significantly. The research and clinical experience of Dr. Caldwell Esselstyn at the Cleveland Clinic has clearly demonstrated that a total cholesterol of less than 150 reduces one’s risk of a heart attack to virtually zero. Yet most of my physician friends (including cardiologists) do not consider this a reasonably attainable goal for themselves or for their patients.

Why? It is “culturally impossible.” It would require a departure from the animal-based foods, high in saturated fats and cholesterol, that comprise the Standard American Diet (SAD). At recent medical conferences that I’ve attended, bacon, sausage, pastries and doughnuts were consumed. In my anecdotal experience over the last 20 years, we doctors generally suffer and die from the same “preventable” chronic diseases as our patients (heart attacks, strokes, diabetes, etc.). I once saw a cartoon of a doctor eating breakfast. In one hand, he held a medical journal whose research concluded that meat contributes to chronic disease. In the other hand, he held a fork with sausage.

The cartoon summarizes the disconnect which I have anecdotally observed. It is my personal observation and conclusion that our reluctance as a medical profession to embrace a plant-based, whole foods diet reflects a general unwillingness to re-examine and critically evaluate our dietary patterns, which are embedded in our culture. Reflecting on our societal imperfections is uncomfortable.

Yet I am optimistic looking towards the future that our approach to chronic disease will change. Continuing medical education programs such as Healthy Kitchens, Healthy Lives (Harvard School of Public Health) and Food as Medicine (Center for Mind-Body Medicine) are now educating more and more physicians and other health professionals about the impact changes in the kitchen can have on chronic disease prevention. When our medical schools begin to engage proactively and impress upon future physicians the need to “walk the talk” with regard to leading healthy lifestyles, we will become better suited as a profession to address the preventive health needs of our patients.

WHAT'S ON YOUR MIND? 2012 HEALTHCARE TRENDS

World Congress is a leading global provider of health care conferences and forges communities by convening senior executives from all segments of the health care industry. The research conducted to produce an event in the World Congress Leadership Summit Series is performed almost entirely through actual interviews with the target market. Consequently, powerful insights can be gained into what is on the minds of myriad stakeholders. The trends which follow reflect what World Congress conference producers have taken away from telephone interviews they've conducted over the last few months on a variety of topics.

1. Trend: Increased Focus on Quality of Care

With health care reimbursements increasingly highlighting the importance of customer satisfaction, both providers and payers have turned their attention even more acutely on improving quality of care. This increased focus is reflected in their staffing choices, professional training programs, and payment models, such as P4P and bundling for episodes of care rather than a purely transactional reimbursement schemata.

2. Trend: Increased Focus on Continuum of Care

The need to create an integrated and streamlined continuum of care is clear. This shift is being seen in all care settings, from the inpatient bed and home care to outpatient services and beyond. Medicare's policy regarding non-reimbursement for readmissions which are deemed avoidable is but one example of the increased expectation that care transitions be planned and coordinated in a manner to ensure a smooth passage from one level of care to another.

3. Trend: Shifting Payment Structure from Volume to Value

Tying patient outcomes directly to reimbursement is driving provider organizations to take greater accountability for the quality of care they provide and the manner in which it is delivered. Accountable care and patient-centered medical home models, as well as federal legislation and policies, all support the transformation from a world of transactions to an arena of results.

4. Trend: An Essential Need for Physician Alignment

As more and more physicians are shifting from independent practice to hospital employment, hospitals are seeking ways to align and engage their physicians. Additionally, physician leaders are emerging as decision-makers who represent the needs of the physician staff, which may differ greatly from the expectations of the C-suite management team. One such example is physician reluctance to be early adopters of technologies such as the EMR (electronic medical record) and CPOE (computerized physician order entry), which may initially be perceived as having a major negative impact on productivity and shifting focus away from direct patient care. As hospitals concentrate more on patient-centered care and consumer satisfaction, it becomes increasingly important to invest in the onboarding process for employed physicians and to create a culture of collaboration.

5. Trend: A Pressing Need to Streamline Health Care Administration with a promise to save the health care system billions of dollars over the next ten years. There is a tremendous governmental push to streamline standards for electronic payment and to manage the "dollars to data issue." By 2014, compliance with HHS Operating Rules for Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERA) for any organization covered by HIPAA will be required. These Rules are designed to help eliminate inefficient manual processes and reduce costs when the provider matches up the claims submission (the "data") with the payment (the "dollars").

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To learn more about Tracy, Alana, Nancy, Lulu and Shay, [click here](#).

WHAT'S ON YOUR MIND? 2012 HEALTHCARE TRENDS *continued*

6. Trend: The Accelerating Pace of Mobile Innovation in the Delivery of Patient-Centered Care

Mobile monitoring and innovative apps offer an opportunity to engage consumers/patients “where they are.” Looking at the increasing evidence that mobile health works, provider organizations and health plans are devising strategies that will encourage broad-based adoption among physicians and other clinicians.

7. Trend: The Increased Use of Social Media in Health Plan Marketing

As more populations increase use of technology relative to their health-care needs, health plans are becoming more active in the use of social media applications to (a) both attract new beneficiaries and retain existing members and (b) serve as a platform for improving health outcomes through such activities as online, condition-specific chat groups.

8. Trend: A Continuing Drive Toward Consumerism

Health care consumers are becoming more engaged and recognizing the need to advocate and be accountable for their own health. This shift is reflected in new hospital initiatives such as shared decision-making and patient advisory councils.

9. Trend: A Movement Towards Remote Treatment for Patients Across a Variety of Sub-Specialties

As technology options increase, more hospitals and health systems are moving towards innovative treatment methods using remote monitoring and coordinated distance care to treat patients.

10. Trend: Using Data Analytics to Improve Patient Care

EMRs, Health Information Exchanges (HIEs), and other health IT advances hold the promise of capturing data from disparate sources. When leveraged effectively, this data can be analyzed to provide a more holistic picture of an individual patient or broader patient population. Providers and payers are finding data-driven opportunities, both to improve clinical outcomes and consumer satisfaction, as well as to achieve medically appropriate cost savings.

For a more in-depth look into the latest trends, [\[click here\]](#).

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